Vision Plan

The City's basic Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Aetna.

Vision Coverage

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an Aetna in-network doctor or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because Aetna network providers discount their fees. And, with in-network providers, you generally do not have to file claims. If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses. To find a network provider, go to **www.aetna.com**.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear. So be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Comprehensive Exam	1 Every Rolling 12 Months	
Lenses (including contact lenses)*	1 Every Rolling 12 Months	
Frames	1 Every Rolling 12 Months	
Routine/Comprehensive Eye Exam Benefit	**NOTE: Medical Plan covers one free eye exam per year.** $10 Copay	Up to $ 25 Reimbursement
Exam Options:		
Standard Contact Lens Fit & Follow Up	Member pays discounted fee	Not Covered
Premium Contact Lens Fit & Follow Up	Member pays discounted fee	Not Covered
Frames (Any available frame at provider location)	$130 Plan Allowance. Member pays 80% of balance over $130	Up to $ 65 Reimbursement
Standard Plastic Lenses:		
Single Vision	$10 Copay	Up to $15 Reimbursement
Bifocal	$10 Copay	Up to $ 30 Reimbursement
Trifocal	$10 Copay	Up to $ 60 Reimbursement
Lenticular	$10 Copay	Up to $ 60 Reimbursement
Standard Progressive Lens	Member Pays $ 85	Up to $ 30 Reimbursement
Premium Progressive Lens	$ 120 Plan Allowance. Member Pays $ 85 (Member pays 80% over $120 Plan Allowance	Up to $ 30 Reimbursement
Lens Options:		
UV Treatment	Member Pays $15	Not Covered
Tint (solid and gradient)	Member Pays $15	Not Covered
Standard Plastic Scratch Coating	Member Pays $15	Up to $ 15 Reimbursement
Standard Polycarbonate – Adults	Member Pays $40	Not Covered
Standard Polycarbonate –Kids >13	Member Pays $40	Up to $ 15 Reimbursement
Standard Anti-Reflective Coating	Member Pays $45	Not Covered
Polarized	Member Pays 80% of Retail	Not Covered

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Contact Lenses (Contact Lens reimbursement includes materials only)		
Conventional	Member pays 85% over $130	Up to $ 90 Reimbursement
Disposable	Member pays 100% over $130	Up to $ 90 Reimbursement
Medically Necessary	$0 Copay	$ 200 Reimbursement
Laser Vision Correction Lasik or PRK from US Laser Network**	15% off retail price or 5% off promotional price	Not Covered
Second Pair Discount	Member can receive up to 40% off additional pairs of eyeglasses. Additional discounts are available on contact lens purchases. Use of this program is unlimited.	Not Covered
Standard Plastic Lenses:		
Single Vision	$10 Copay	Up to $20 Reimbursement
Bifocal	$10 Copay	Up to $20 Reimbursement
Trifocal	$10 Copay	Up to $20 Reimbursement
Lenticular	$10 Copay	Up to $20 Reimbursement
Standard Progressive Lens	Member Pays $75	Up to $20 Reimbursement
Premium Progressive Lens	Member Pays $75 (Member pays 80% over $120 Allowance	Up to $20 Reimbursement
Lens Options:		
UV Treatment	Member Pays $15	Not Covered
Tint (solid and gradient)	Member Pays $15	Not Covered
Standard Plastic Scratch Coating	Member Pays $15	Not Covered
Standard Polycarbonate – Adults	Member Pays $40	Not Covered
Standard Polycarbonate –Kids >13	Member Pays $40	Not Covered
Standard Anti-Reflective Coating	Member Pays $45	Not Covered
Polarized	Member Pays 80% of Retail	Not Covered

Employee Contributions

Below are the premiums that are in effect January 1, 2013 - December 31, 2013.

Aetna Vision Plan Monthly Rates				
TIER	2012 RATE	2013 RATE	CITY PAYS	MONTHLY DEDUCTION
Employee	$ 6.00	$ 5.77	$ 5.77	$ 0.00
Employee & Spouse	$ 9.14	$ 10.97	$ 6.00	$ 4.97
Employee & Child(ren)	$ 11.50	$ 11.55	$ 6.00	$ 5.55
Family	$ 14.54	$ 16.95	$ 6.00	$ 10.95

Your cost for Medical, Dental and Vision plans in the Benefits Program will be paid on a **before-tax basis** through your payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.